Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address:	MFDR Tracking #: M4-09-A374-01
DR AHMED KHALIFA 1415 S HWY 6 SUITE 400D SUGARLAND TX 77478	
Respondent Name and Box #:	
CITY OF HOUSTON REP. BOX # 42	

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Position Summary: "Fee guideline."

Principal Documentation:

1. DWC 60 package
2. Total Amount Sought - $292.08
3. CMS-1500
4. Explanation of Benefits (EOBs)
5. Medical Report

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: "The carrier's representative received the bill on 03-03-09 for the first time which is greater than 95 days. A copy of the submitted provider's bill has been supplied for documentation."
Principal Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF FINDINGS

Eligible Dates of Service (DOS)	Disputed Service	Denial Codes	Part V Reference	Amount Ordered
11/14/08	CPT code 99245-Office Consultation	29, 193	1-3	$0.00
Total Due:				$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule 134.203, titled ***Medical Fee Guideline for Professional Services*** effective for professional medical services provided on or after March 1, 2008, set out the reimbursement guidelines.

1. These services were denied or reduced by the Respondent with reason codes:
   - 29-The time limit for filing has expired.
   - 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

2. Rule 102.4(h), titled General Rules for Non-Commission Communication, states "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on:

   (1) the date received, if sent by fax, personal delivery or electronic transmission or,
   (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday."

3. Section 408.027(a) of the Labor Code states, "A health care provider shall submit a claim for payment to the insurance carrier not later than the 95th day after the date on which the health care services are provided to the injured employee. Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment." The parties submitted facsimile cover sheets that support the claim was filed on 3/2/09 at 8:07:57pm and 4/16/09 at 12:15:12pm.The disputed date of service is 11/4/08. Based upon the submitted facsimile reports, the date the claim was originally filed was 119 days from date of service; therefore, it was untimely filed. As a result $0.00 recommended for reimbursement.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code 402.00128(b)(7)
Texas Labor Code 408.027(a)
28 Texas Administrative Code Sec. §102.4(h)

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the Requestor is not entitled to additional reimbursement for the services involved in this dispute.

DECISION:

Authorized Signature	Medical Fee Dispute Resolution Officer	11/20/09 Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.